

ACO Contracting With Private and Public Payers: A Baseline Comparative Analysis

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Private and public insurers continue to pursue implementation of the accountable care organization (ACO) model, a value-based payment and delivery model in which a group of providers is held accountable for the cost and quality of care for an assigned patient population. ACOs are present in 55% of local healthcare markets,¹ and recent estimates suggest that more than 14% of patients receive their care from a provider that is part of an ACO.²⁻⁴ State Medicaid agencies have also developed ACO models,⁵ as have a number of private insurers, including Aetna, Blue Cross Blue Shield associations, Cigna, and United HealthCare.^{6,7} Despite the number of provider organizations implementing the ACO model and the growing understanding of Medicare ACO programs, little is known about what types of ACO contracts are being pursued with commercial payers and what types of provider organizations hold these contracts or the details of these contracts.

Understanding the nature of ACO contracts is critical to even beginning to understand the potential effect of the ACO model on healthcare costs and quality. Critics of the ACO model have suggested that most ACOs will have difficulty implementing the infrastructure they need to effectively manage downside risk.⁸ This raises questions about the characteristics of provider organizations that choose to sign an ACO contract involving financial risk. In addition, some have argued that ACO contracts, despite their ostensible emphasis on incentivizing quality, will in reality mirror managed care of the 1990s and potentially encourage physicians to skimp on necessary care to produce cost savings.⁹ Done correctly, ACO contract incentive structures could lead to desired outcomes of reduced costs and increased quality. But done poorly, incentive structures may lead to unanticipated consequences, such as inciting “upcoding,” to game risk adjustment schemes¹⁰ or encouraging physicians to attract low-risk patients, as some argue has happened in Medicare managed care.¹¹⁻¹³ Before researchers and policy makers can assess these issues, a clear understanding of ACO contracts and their incentive structures is key.

ABSTRACT

Objectives

The accountable care organization (ACO) model is currently being pursued by private insurers, as well as federal and state governments. Little is known, however, about the prevalence of private payer ACO contracts and the characteristics of contract structures or how these compare with public ACO contracts.

Study Design and Methods

Cross-sectional analysis of the National Survey of Accountable Care Organizations (n = 173) on ACO contracts with public and private payers and private payer contract characteristics.

Results

Most ACOs had only 1 ACO contract (57%). About half of ACOs had a contract with a private payer. The single most common private payer ACO contract was an upside-only shared savings model (41%), although the majority of private contracts included some form of downside risk (56%). A large majority of contracts made shared savings contingent upon quality performance (79%), and some included bonus payments for quality performance (39%). Most private payer contracts included upfront payments, such as care management payments (56%) or capital investment (17%). Organizations with private ACO contracts were larger and more advanced than ACOs with only public payer contracts.

Conclusions

While there are fewer ACOs with commercial contracts than public contracts, commercial contracts are more likely to include both downside risk and upfront payments.

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Past attempts to characterize ACO contracts have focused on the arrangements of a singular insurer,¹⁴ a single compound of care (such as behavioral health),¹⁵ or the experiences of small convenience samples.^{2,16-18} In this study, we use new data from the National Survey of ACOs^{18,20} to systematically examine the prevalence of various types of ACO contracts (eg, Medicare, Medicaid, and commercial), the components of commercial payer contracts, and the capabilities of the organizations that are pursuing commercial payer contracts. Our data provide the first comprehensive, systematic picture of the commercial ACO contract landscape. Our results illuminate how commercial ACO contracts compare with public ACO contracts, as well as what types of provider organizations are pursuing each type of contract.

ACO CONTRACT FEATURES

We define an ACO contract as a contract that holds a group of providers collectively responsible for both the total cost of care and the quality of care for a defined patient population. Notably, this definition excludes several types of contracts that some may classify under the broad umbrella of “accountable care”: pay-for-performance that does not include responsibility for total cost of care, and capitation without a major quality component. Additionally, this definition excludes organizations that are self-identified ACOs without a corresponding ACO contract.

ACO contracts may vary significantly in their design, including the level of financial risk assumed by the provider organization (ie, are providers eligible only for gains or are they responsible for any losses incurred?) and how the cost and quality of care are measured and rewarded. **Table 1** provides illustrative examples of some major public and commercial payer ACO contracts. ACO contracts are generally based on one of 3 payment arrangements: shared savings, global budgets, and capitated payments. Under shared savings models, providers are reimbursed via fee-for-service, and at the end of the year split with the payer any savings generated (as measured against prespecified benchmarks). Providers are often eligible to keep a larger proportion of these savings if they also agree to share in any losses or costs above prespecified benchmarks. The Medicare Shared Savings Program is a version of this type of contract. Under a global budget model, providers have a predetermined global budget for their assigned patient population that is reconciled at the end of the year. If

Take-Away Points

This study drew from a national survey of accountable care organizations (ACOs) to examine the prevalence of private payer ACO contracts and the characteristics of contract structures, as well as to determine how these compare with public ACO contracts.

- The majority of ACOs had only 1 ACO contract, and about half of ACOs had a contract with a private payer.
- Private payer ACO contracts were most often shared-savings models, and the majority of private contracts included downside risk.
- Organizations with private ACO contracts were larger and more advanced than ACOs with only public payer contracts.

costs are below the global budget, the ACO retains these savings; if costs are above the global budget, the ACO is responsible to pay back some or all of these losses. Under a capitated model, providers are paid in advance a set amount per assigned ACO patient and often bear full financial risk; they are responsible for any costs they incur above their capitated payment but retain any savings if their costs are below the capitated payment.

ACO contracts may reward quality through 3 major mechanisms. First, shared savings contracts can make all or a portion of shared savings contingent upon quality performance. In the Medicare Shared Savings Program, for example, providers can only share in savings if they meet quality benchmarks. Second, contracts may provide bonuses for quality performance. For example, the Alternative Quality Contract model paid providers bonuses above their global budget for achieving quality benchmarks. Finally, contracts may withhold a portion of payment and return it—contingent upon quality performance. For example, under the Hennepin Health ACO arrangement, a portion of the capitated payment is withheld and returned to the providers only if the providers meet quality benchmarks.

METHODS

Survey Design

We used data from the National Survey of Accountable Care Organizations (NSACO) for this study. We designed the survey to capture key characteristics and capabilities of ACOs, along with the perspectives and outlook of their leaders. The Web and telephone survey included questions on ACO contracts, leadership, structure, organizational capabilities, and local context, as well as questions designed to understand respondents’ views on the potential of the ACO model ([eAppendix](#), available at www.ajmc.com). These questions were designed based on frameworks for evaluating ACOs,²¹ other surveys, and interviews with ACOs. The survey was completed by executive- or director-level individuals at identified ACOs.

■ **Table 1.** Examples of ACO Contract Structures

Type of Contract	Payment Structure	Risk Arrangement	Quality Payments
Medicare Contracts			
Shared Savings Program Track 1	Fee-for-service with shared savings	Upside only: ACO has potential only for gain	Savings contingent on meeting quality benchmarks
Pioneer Program Core Payment	Fee-for-service with shared savings and transition to prospective population-based payments, reconciled to shared savings and losses at year end	Upside and downside risk: ACO has potential for gain and loss	Savings contingent on meeting quality benchmarks
Private Insurer and Medicaid Contracts			
Blue Cross Blue Shield of Massachusetts Alternative Quality Contract	Global budget	Upside and downside risk: ACO has potential for loss if costs exceed global budget and gain if costs are below global budget	Bonuses paid for quality performance
Hennepin Health ACO with Minnesota Medicaid	Capitated payment	Upside and downside risk: ACO has potential for loss if costs exceed capitated payment and gain if costs are below capitated payment	Portion of capitation withheld and returned based on quality performance

ACO indicates accountable care organization.

Survey Population

For inclusion in our study sample, we attempted to identify all ACOs that had been established by August 2012. Medicare and state Medicaid ACO program participant lists were publicly available. ACOs involving private insurers were identified from multiple sources, including Web searches, press releases, membership lists of ACO collaboratives, and previous surveys that had identified ACOs. In total, we identified 292 organizations potentially eligible for our survey. A set of screening questions at the beginning of the survey determined if a respondent had an ACO contract and was therefore eligible for the survey. Our survey was completed by 173 eligible ACOs between October 2012 and May 2013, with a response rate of 70%. The eAppendix includes more details on the survey design, population, and response rate.

Measures

The NSACO included a number of questions specific to ACO contracts and contract structures. Respondents were asked to indicate whether they were participating in Medicare and Medicaid ACO programs and to list up to 4 ACO contracts with private insurers. We only included contracts with private insurers if the provider organization had a signed letter of agreement in place or a signed contract.

Respondents were asked several questions on the structure of their largest contract with a private insurer (defined by the number of attributed patients), including

payment and risk arrangements and total cost-of-care calculations. In our analysis, we describe the distribution of contract types and the structure of those contracts. We also compare the characteristics and capabilities of organizations with differing contract types (public vs private only, risk-bearing vs not risk-bearing).

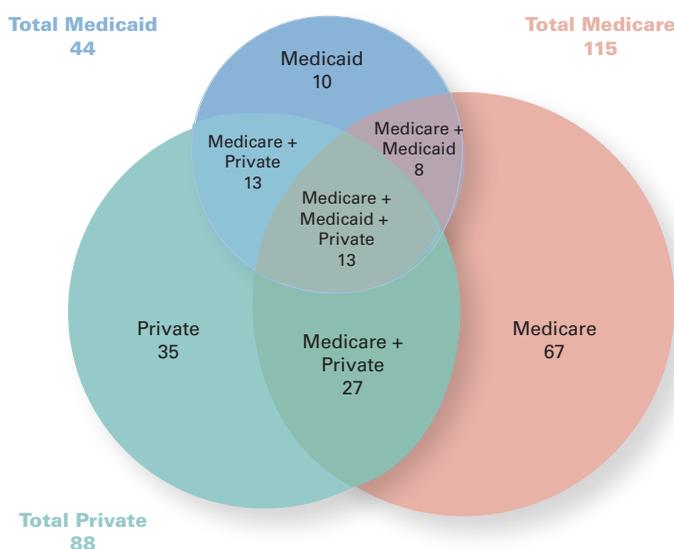
RESULTS

Just over half of the respondents (51%) had an ACO contract with a private insurer (Figure), two-thirds had an ACO contract with Medicare either through the Pioneer Program or the Medicare Shared Savings Program, and a quarter had a Medicaid ACO contract. Most organizations had only one ACO contract (57%). Blue Shield Blue Cross associations represented the most common private payer (Table 2).

Respondents were asked to describe attributes of their largest ACO contract with a private insurer (Table 3). Private payer ACO contracts were most often shared savings models (69%). Most private payer contracts included downside risk (56%), either through capitation, global budgets, or shared savings models that included shared losses. In comparison, only 7% of Medicare Shared Savings Program contracts included downside risk. All Pioneer ACO contracts, by design, include some level of downside risk during the contract period.

Respondents reported that under private payer ACO contracts, the ACO received a mean of 56% of shared sav-

■ **Figure.** Overlap of Private and Public ACO Contracts Among Survey Respondents (N = 173)



ings generated. In comparison, providers with upside risk only in the MSSP receive 50% of savings generated, those under MSSP with downside risk receive 60% of savings, and Pioneer ACOs receive 80% of savings. A large majority of private contracts made shared savings contingent upon quality performance (79%), a finding similar to the Medicare programs. Some ACO contracts included bonus payments for quality performance (39%), either in addition to contingent shared savings or as quality payments for those under capitation or global budgets. Most private payer contracts included upfront payments, such as care management payments (56%) or capital investment (17%).

We next examined what services are included in the total cost of care for which providers are held responsible under private payer ACO contracts. Nearly all contracts held ACOs responsible for costs associated with emergency department care, outpatient care, inpatient care, labs and x-rays, advanced imaging, and professional services (98% to 100%). Fewer included pharmacy (78%); durable medical equipment (78%); mental health or substance abuse services (60%); and vision, hearing, and speech services (50%). Medicare ACO contracts, by comparison, do not include pharmacy, vision, or hearing in the total cost of care calculation, but do include mental health and durable medical equipment.

The mean length of a private payer contract was 3.2 years, with a range of 1 year to 9 years. Contract size varied across Medicare, Medicaid, and private payers (not shown in table). Medicare Shared Savings Program participants are required to have a minimum of 5000 attributed beneficiaries, while Pioneer Program participants must have

■ **Table 2.** Distribution of Private, Public, and Risk-Bearing ACO Contracts Among Survey Respondents

Type of ACO Contract	Percent of Total (N = 173)
Private Contract	51%
Blue Cross Blue Shield	32%
Cigna	10%
Aetna	6%
United HealthCare	5%
Other or Undisclosed Payer	19%
Medicare Contract	66%
Medicare Shared Savings Program	52%
Pioneer Program	15%
Medicaid Contract	25%
Single Payer	57%
Public contract	45%
Private contract	13%
Multiple Payers	43%
Multiple private contracts	24%
Private and public contract(s)	31%
Risk-Bearing Contract	40%
Risk-bearing Medicare contract	19%
Risk-bearing private contract	28%

ACO indicates accountable care organization.

15,000 in most cases. However, a number of private payer ACO contracts (21%) cover fewer than 5000 beneficiaries.

We compared contract features and size across specific private payers for ACO contracts. We found across the board that there was common variation on contract characteristics among payers. For example, there were similar

■ **Table 3.** Characteristics of Largest Private ACO Contracts as Reported by Survey Respondents

Contract Characteristics (N = 88)	
Length of Contract	3.2 years
Contract Arrangement^a	
Shared savings model, no downside risk	41%
Shared savings model, includes downside risk	28%
Global budget under fee-for-service payment	8%
Partial capitation	6%
Full capitation	14%
Other	3%
Upfront Payments	
Care management or care coordination payment	56%
Capital investment	17%
Advances on shared savings	4%
Shared Savings and Quality Payments	
Shared savings contingent on quality performance	79%
Payment model includes additional bonus payments	39%
Mean proportion of savings shared with ACO	56%
Components of Total Cost of Care Calculation	
Emergency department	100%
Inpatient	99%
Lab / x-ray	99%
Outpatient	99%
Advanced imaging	98%
Professional services	98%
Durable medical equipment	78%
Pharmacy	78%
Mental health / substance abuse	60%
Vision, hearing, and speech services	50%
Dental	7%

^aContract arrangement indicates contract structure at end of contract period if the arrangement changes during the contract period. Of respondents with private ACO contracts, 31% reported their arrangement changed during the contract period.

proportions of risk-bearing contracts, upfront payments, and services included in the total cost of care across the private payers shown in [Table 2](#).

We conducted some additional analyses on private payer contracts not presented in our tables. First, we examined common structures of private payer ACO contracts. The most common structure involved a shared savings model with no downside risk, under which receipt of shared savings was contingent on meeting prespecified quality metrics ($n = 20$). These structures mirror the financial model of the Medicare Shared Savings Program.

Additionally, respondent organizations were asked whether they believed the amount of risk they would be assuming in their largest commercial ACO contract would be sufficient to influence their behavior to try to achieve targeted cost and quality goals. More than 60% indicated they “agreed” or “strongly agreed” that the risk they assumed in their first performance year would be sufficient. Interest-

ly, the proportion agreeing or strongly agreeing did not differ significantly between those without downside risk (64%) and those whose contracts included downside risk (62%).

Finally, we examined characteristics of organizations with private payer ACO contracts compared to those with only a public payer contract (Medicare or Medicaid) to understand systematically what kinds of provider organizations were taking on private payer ACO contracts ([Table 4](#)). Organizations with private ACO contracts were more advanced than those with only public ACO contracts: they were significantly more likely to be an integrated delivery system (69% vs 36%) or include a hospital (72% vs 53%). ACOs with private contracts also had somewhat higher care management capabilities (38% vs 28%) and levels of meaningful use among primary care physicians (43% vs 37%), although neither of these differences were statistically significant. In addition, organizations with private ACO contracts had greater numbers of participating providers: ACOs with private contracts had significantly more full-time-equivalent primary care physicians (219 vs 138) and specialists (342 vs 137). Notably, organizations with private ACO contracts were more likely to have experience with pay-for-performance initiatives than organizations with only public ACO contracts, although they had similar levels of experience with other health reform efforts, including patient-centered medical homes, public reporting, and risk-based contracts.

Similar results were observed when comparing the capabilities of ACOs that indicated they bear financial risk as part of their ACO contracts compared with those that do not. Along with more experience with pay-for-performance initiatives (97% vs 85%), risk-bearing ACOs also had significantly more experience with various other healthcare reform efforts, including public reporting (92% vs 80%) and risk-based contracts (83% vs 55%).

DISCUSSION

This work provides some of the first empirical evidence on the nature of private payer ACO contracts, the characteristics of ACOs with private payer contracts, and how those organizations compare with other ACOs. ACO contracts are relatively new, with Medicare initiating pilots in 2005 and broad programs in 2012, and private payers piloting contracts beginning in 2009.

Among private contracts, only the Alternative Quality Contract (a Blue Cross Blue Shield program in Massa-

■ **Table 4.** Comparison of Characteristics of Respondents With Private ACO Contracts vs Those With Only Public ACO Contracts

ACO Characteristics	Private (N = 88)	Public Only (N = 85)	P on Difference	Bearing Risk (N = 70)	Not Bearing Risk (N = 103)	P on Difference
Integrated Delivery System	69%	36%	<.001	65%	46%	.017
ACO Participants						
Hospital	72%	53%	.018	82%	51%	<.001
FQHC or RHC	23%	33%	.173	31%	26%	.516
Nursing facility	20%	25%	.407	26%	20%	.366
FTE primary care physicians (No.)	219	138	.003	225	146	.004
FTE specialists (No.)	342	137	<.001	349	165	<.001
ACO Capabilities						
High care management capabilities	38%	28%	.212	41%	28%	.111
High meaningful use attestation	43%	37%	.433	35%	43%	.289
ACO Experience						
Pay for performance	94%	85%	.058	97%	85%	.014
Patient-centered medical home	89%	84%	.354	89%	85%	.456
Public reporting	87%	83%	.523	92%	80%	.038
Prior risk-based contracts	67%	67%	1.000	83%	55%	<.001
ACO indicates accountable care organization; FQHC, federally qualified health center; FTE, full-time equivalent; RHC, rural health center.						
^a Along with respondents that have assumed financial risk vs those that have not.						

chusetts) has been described in detail publicly. Our results show that private payer ACO contracts are varied in nature with different types of incentive programs in place. The single most common type of commercial contract is upside shared savings only (41%) with no risk for overspending; although when one combines all types of risk bearing (shared savings with downside risk, global budget, and capitation), the majority of commercial-payer ACOs are under contracts that include downside risk. Most contracts reward quality by basing financial rewards (ie, shared savings) on quality. Additionally, unlike Medicare ACO contracts, most commercial-payer ACO contracts include upfront payments, typically in the form of care coordination or care management payments.

In addition to shedding light on the nature of private payer ACO contracts, this work examines the types of ACOs that currently have private payer contracts and how they compare with ACOs with only public payer contracts. Public ACO programs, in particular Medicare, are the largest force in the ACO movement, with 80% holding an ACO contract with Medicare or Medicaid, compared with only 50% holding an ACO contract with a private payer. Medicare contracts may be most common for a variety of reasons: our results show ACOs with commercial contracts may have more care management and information technology capabilities than ACOs with only Medicare and/or Medicaid ACO contracts, suggesting that less advanced organizations may first pursue public ACO contracts. Medicare contracts may also be perceived as more straightforward. Rather than involving a negotiation with a commercial payer, joining the

Medicare Shared Savings Program involves submitting an application. The program's prespecified quality measures and financial benchmarking may be more manageable for provider organizations to understand and do not require them to negotiate on complex or unfamiliar terms. In addition, anecdotal evidence suggests that provider organizations may view the anti-trust protections under Medicare ACOs as an important benefit. Finally, it is possible that organizations more tentative in their approach to payment reform are using the Medicare Shared Savings Program to gain experience without being responsible for downside risk.

Our analysis faces some limitations. First, our survey population includes only those ACOs with private contracts for which some information was publicly available, as described in the methods. Organizations that have private payer ACO contracts that are confidential or have no public information (and the ACO has no public payer ACO contracts) were not included in our survey population. Therefore, we had no way to determine the true population of commercial ACOs. Second, the private contracts described in this analysis represent the largest commercial ACO contract per organization and our analysis of contract characteristics was limited to 1 commercial contract per organization. If larger ACO contracts are systematically different from smaller contracts, then our results on the nature of commercial payer ACO contracts may be biased (eg, if smaller contracts tend to less often include downside risk). Finally, our analysis is limited to ACOs that were established as of August 2012. The field of ACOs is rapidly developing, and continuing research on ACO contracts is

necessary to understand how contracts are developing and changing.

Medicare has offered 2 programs that have attracted a large number of ACOs in the first 2 years. With 32 organizations starting in the Pioneer Program and 220 entering in the Medicare Shared Savings Program in 2012 and 2013, Medicare is leading the field in the move away from traditional fee-for-service payment. In fact, the Pioneer program requires that greater than 50% of the ACO's patients must be covered by risk-based contracts in the first few years, necessitating changes in commercial contracts. While more organizations are testing the water with a Medicare Shared Savings Program contract with upside shared savings only, commercial contracts are more likely to include downside risk, which some have hypothesized will produce larger reductions in cost growth. However, we do not know, for example, if risk bearing will be more important than the proportion of patients an organization has under ACO contracts.

Medicare has been relatively flexible in terms of the types of providers it accepts into the Shared Savings Program, and has allowed organizations to join that have only upside potential. These program characteristics may influence participating providers. It may be that commercial ACO contracts will gain momentum in the next few years as payers and providers gain experience with these contracts. Researchers should continue to track the evolution of ACO contracts and eventually measure the relationship between contract characteristics and performance.

As performance information becomes available, it will be important to understand nuances in contract design and association with differences in cost and quality. Learning across Medicare, Medicaid, and commercial contracts can allow each to learn from one another and iteratively work toward the best possible contracts. This information will enable public and private payers to learn which types of contracts and incentives work best in different contexts and how to improve ACO contracts.

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eAPPENDIX:

THE NATIONAL SURVEY OF ACCOUNTABLE CARE ORGANIZATIONS

Survey Design

The National Survey of Accountable Care Organizations (NSACO) was developed to collect detailed information on accountable care organizations (ACOs). The survey instrument was constructed based on questions from existing healthcare provider surveys, qualitative interviews with ACOs, and frameworks for evaluating ACOs.^{1,2} The survey includes questions on ACO contracts; care management, quality improvement, and health information technology capabilities; participation and experience with payment reform; ACO governance and leadership structure; and attitudes toward the ACO model.

The first wave of the survey was fielded from Oct 2012 through May 2013. At each ACO, based on conversations with ACO staff and leadership, we identified the individual best positioned to complete the survey. When necessary to complete the survey, we encouraged respondents to get information they were unfamiliar with from someone else at their organization.. Respondents were generally executive- or director-level staff at the ACO, such as c-suite executives, executive directors, or vice presidents. The survey was primarily fielded as a web-based survey, but respondents were also given the option of answering by phone. In the end, 98% of respondents completed the web-based survey, and only 2% (3 respondents) opted to complete the survey by phone.

Survey Population

We defined an ACO as a group of healthcare providers collectively responsible for the total cost of care and quality of care for a defined patient population. This means that an organization must have a contract with a payer that holds them responsible for both cost and quality of care. This removes from our universe of ACOs organizations under pay-for-performance contracts with no responsibility for cost, providers under capitation with no significant quality payments, and organizations that are self-declared ACOs with no associated payer contract.

We used a variety of sources to identify the universe of likely ACOs. We began with participants in Medicare ACO programs, the Pioneer ACO program, and the Medicare Shared

Savings Program. All participants in these programs met our definition of an ACO and were automatically eligible for our survey. Additionally, we identified ACOs that were participating in state ACO programs or demonstrations that met our definition, such as the Oregon Coordinated Care Organizations and participants in Minnesota's Health Care Delivery System Demonstration; these participants were identified through public announcements or communication with state Medicaid officials.

Finally, we needed to identify provider groups that had ACO contracts with private payers. No national database of these private payer ACOs exists, so we identified these ACOs through a variety of sources, including participation in ACO implementation or learning collaboratives, such as those run by Brookings-Dartmouth, Premier, and the American Medical Group Association; published ACO case studies; ACO certification from the National Committee for Quality Assurance; communication with major payers; and announcements of ACO contracts, such as press releases. Among these organizations, we did not know *a priori* which would meet our relatively strict definition of an ACO. As a result, we included questions in the survey to screen for eligibility, as discussed in the next section. In total, we identified 292 organizations that were potentially eligible for the survey and were invited to participate.

Eligibility and Response Rate

The NSACO began with a set of screening questions to determine if a respondent met our criteria for being an ACO and was therefore eligible for the full survey. Of the 292 organizations invited to participate, 30 respondents completed screening questions and were deemed to not meet our ACO criteria. A total of 173 eligible respondents completed the full survey. Taking into account unknown eligibility for the potential private-payer ACOs, we had a final response rate of 70% based on the American Association for Public Opinion Research methodology.³

The NSACO response rate was higher for Medicare ACOs (81%) and lower for state Medicaid ACOs (48%). We compared the distribution of our completed responses from Medicare ACOs to the distribution of all Medicare ACOs.⁴ Our distribution was very similar to the full distribution across measures such as involvement of hospitals or federally qualified health centers. Given these results, we decided there was not any major observable nonresponse bias, and thus no need to create survey weights based on nonresponse.

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